METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – NURSING HOME SERVICES

The following sections summarize the methods and procedures for determining nursing facility reimbursement rates in the format prescribed by the Department of Health and Human Services (DHHS). Effective July 1, 1999, the Department will use the 1998 cost reports as the basis for setting reimbursement rates for nursing facilities. Complete documentation is found in the Policies and Procedures for Nursing Facility Services manual, Chapter 1000, included as an attachment to this exhibit.

A. Cost Finding and Cost Reporting

1. All nursing facilities are required to report costs for the twelve months ending June 30th of each year.

2. All nursing facilities are required to detail their costs for the entire reporting year, or for the period of participation in the plan (if less than the full cost reporting year) for allowable costs under the Georgia Plan. These costs are reported by the facility using a Uniform Chart of Accounts prescribed by the State Agency and on the basis of generally accepted accounting principles and accrual methods of accounting.

3a. All nursing facilities are required to report costs on a uniform cost report form provided by the State Agency on or before September 30 of the year in which the reporting period ends. Hospital-Based facilities using Medicare fiscal year ending dates between May 31 and June 30 must submit cost reports on or before November 30. Those using Medicare fiscal year ending dates between July 31 and September 30 must submit cost reports on or before December 31 using the most recent complete fiscal year cost data.

3b. All nursing facilities are required to submit to the Department any changes in the amount of or classification of reported costs made on the original cost report within thirty days after the implementation of the original cost report used to set reimbursement rates. Adjustments to amounts or

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changes in classification of reported costs in prior years will not be considered.

4. All nursing facilities are required to maintain financial and statistical detail to substantiate the cost data reported for a period of at least three years following the date of submission of the cost report form to the State Agency. These records must be made available upon demand to representatives of the State Agency or the DHHS.

5. The State Agency shall retain all uniform cost reports submitted in accordance with paragraph 3a above for a period of three years following the date of submission of such reports, and will properly maintain those reports.

B. Audits

1. The State Agency has, as needed, updated and revised resource materials developed in prior years through the accomplishment of the following tasks:

   (a) The development of standards of reasonableness for each major cost center of a nursing facility;

   (b) The development of a computerized desk review process for the submitted uniform cost reports; and

   (c) The development of a detailed on-site audit plan, using generally accepted auditing standards.

   The standards, desk review, and on-site audits ensure that only expense items allowable

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under the Georgia Plan, as detailed under Section C of this attachment, are included in the facility's uniform cost report and that the expense items included are accurately determined and are reasonable.

2. The State Agency will conduct analyses of the uniform cost reports for the reporting year ending the previous June 30th to verify that the facility has complied with paragraphs 2 and 3 above in Section A.

3. Where the analyses conducted, as specified in paragraph B 2 above, reveal that a facility has not complied with requirements, further auditing of the facility's financial and statistical records and other documents will be conducted as needed.

4. On-site audits of the financial and statistical records will be performed annually in at least 15 percent of participating facilities. Such on-site audits of financial and statistical records will be sufficiently comprehensive in scope to ascertain whether, in all material respects, the uniform cost report complies with Section B, Paragraph 1 above.

5. The on-site audits conducted in accordance with Section B, paragraph 4 above shall produce an audit report which shall meet generally accepted auditing standards. The report shall declare the auditor's opinion as to whether, in all material respects, the uniform cost report includes only expense items allowable under the Georgia Plan, as detailed under Section C of this attachment, and that the expense items included are accurately determined, and are reasonable. These audit reports shall be kept by the State Agency for at least three years following the date of submission of such reports, and will be properly maintained.

6. Any overpayments found in audits under this paragraph will be accounted for on Form HCFA-64 no later than 60 days from the date that the final rate notification is sent to the nursing facility.

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C. Allowability of Costs

The Department uses the Health Care Financing Administration Manual (HCFA-15-1), Medicare principles, as a guide to determine allowable and non-allowable costs. However, in situations where warranted, the Department has developed policy regarding cost allowability outside of HCFA-15-1. In addition to the use of HCFA-15-1 as a guide, the Department describes specific cost allowability in the Policies and Procedures for Nursing Facility Services manual, Chapter 1000, which is included as an attachment. The following paragraphs offer a general discussion of allowability of costs.

1. Allowable Costs Include the Following:

a) The cost of meeting certification standards. These costs include all items of expense which providers must incur to meet the definition of nursing facilities under Title XIX statutory and regulatory requirements and as otherwise prescribed by the Secretary of HHS for nursing facilities; in order to comply with requirements of the State Agency responsible for establishing and maintaining health standards; and in order to comply with any other requirements for nursing facility licensing under the State law;

b) All items of expense which providers incur in the provision of routine services. Routine services include the regular room, dietary and nursing services, minor medical and surgical supplies, and the use of equipment and facilities. Additional allowable costs include depreciation, interest, and rent expense as defined in the principles of reimbursement in HFCA-15-1, except that actual malpractice insurance costs are reimbursed as reported in the facility's cost report, subject to audit verification; and

c) Costs applicable to services, facilities, and supplies furnished to a provider by common ownership or control shall not exceed the

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lower of the cost to the related organization or the price of comparable services, facilities, or supplies purchased elsewhere. Providers are required to identify such related organizations and costs on the State's uniform cost report.

2. Non-Allowable Costs Include the Following:

a) Bad debts of non-Title XIX program patients and charity and courtesy allowances shall not be included in allowable costs. The only bad debts allowable are those defined in 42 CFR 413.80. The value of operating rights and licenses and/or goodwill is not an allowable cost and is not included in the computation of the return on equity;

b) Effective for the determination of reasonable costs used in the establishment of reimbursement rates on and after April 1, 1991, the costs listed below are nonallowable.

- Costs related to lobbying and government relations, including costs for employees with duties related to lobbying and government relations, honorariums and reimbursement of travel or other expenses of elected officials;

- Memberships in civic organizations;

- Out-of-state travel paid by the provider for persons other than board members or those employed or contracted by the provider. Out-of-state travel for provider personnel must be related to patient care;

- Vehicle depreciation or vehicle lease expense in excess of the lesser of IRS limits per vehicle or the amount allowed under Medicare reimbursement principles; provided, however, such

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limits shall not apply to specialized patient transport vehicles (e.g. ambulances);

- Air transport vehicles that are not used to transport patient care staff or patients. If these vehicles are sometimes used for patient care staff or patient transport, the portion of cost that is unrelated to patient care staff or patient transport is nonallowable;

- Fifty percent (50%) of membership dues for national, state and local associations;

- Legal services for an administrative appeal or hearing, or court proceeding involving the provider and the Department or any other state agency when judgement or relief is not granted to the provider. Legal services associated with certificate of need issuance reviews, appeals, disputes or court proceedings are not allowable regardless of outcome. Legal services associated with a provider's initial certificate of need request shall be allowable;

- Advertising costs that are (a) for fund raising purposes; (b) incurred in the sale or lease of a facility or agency or in connection with issuance of the provider's own stock, or the sale of stock held by the provider in another corporation; (c) for the purpose of increasing patient utilization of the provider's facilities; (d) for public image improvement; or (e) related to government relations or lobbying; and

- The cost of home office vehicle expense.

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D. Methods and Standards for Determining Reasonable Cost-Related Payments

1. Nursing Facility and ICF/MR Methods and Standards

The methods and standards for the determination of reimbursement rates to nursing facilities, and intermediate care facilities for the mentally retarded is as described in Chapter 1000 of the Policies and Procedures for Nursing Facility Services manual which is included as an attachment.

2. Rates Take Into Account Economic Trends

Payment methods and standards utilized to establish prospective rates will reasonably take into account economic conditions and trends during the time period covered by the rates through the application of a growth allowance factor to historical costs. Effective July 1, 1999, the basis of nursing facility rates is the 1998 cost report with a growth allowance of 6.2%. The 6.2% growth allowance is based on the inflation factor contained in the publication titled DRI McGraw-Hill Health Care Costs for nursing facilities adjusted for the time delay between the reporting period and the reimbursement period. The cost report period and growth allowance may be updated periodically.

3. Prospective Rates

Payment rates to nursing facilities and ICF/MR's are determined prospectively using costs for a base period.

4. Determination of Payment Classes

Classes are determined in accordance with Section 1002 of the Policies and Procedures for Nursing Facility Services manual.

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5. Prospective Rates For Facilities with Service Deficiencies

The State does not adjust rates based on service deficiencies or quality of service.

6. Additional Details

Detailed information regarding this methodology is maintained on file in the State Agency as Chapter 1000 of the Policies and Procedures for Nursing Facility Services manual, included as an attachment.

E. Payment Assurances

The State will pay each provider of nursing care services, who furnishes the services in accordance with the requirements of the State Plan, the amount determined for services furnished by the provider under the Plan according to the methods and standards set forth in Section D, above.

In no case shall the payment rate for services provided under the plan exceed the facility's customary charges to the general public for such services.

F. Provider Participation

Payments made in accordance with methods and standards described in this attachment are designed to enlist participation of a sufficient number of providers of services in the program; so that eligible persons can receive the medical care and services included in the State Plan at least to the extent these are available to the general public.

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G. Payment in Full

Participation in the program shall be limited to providers of service who accept, as payment in full, the amounts paid in accordance with the State Plan.

H. Payment Limitation Applicable to Patients in Nursing Facilities with Medicare Part A Entitlement

Effective with dates of payment of February 1, 1991, and after, the maximum allowable payment for Medicare nursing facility coinsurance (crossover) claims will be the nursing facility's Medicaid specific per diem rate in effect for the dates of services of the crossover claims. The crossover claims will not be subsequently adjusted due to subsequent per diem rate adjustments.

Daily cost-sharing charges for beneficiaries will commence on the 21st day of service through the 100th day of service. These patients must be eligible for Part A Medicare and be admitted to an approved Medicare facility under conditions payable by Medicare.

I. Nurse Aide Training

The Department adjusts per diem payment rates to reimburse the costs associated with replacement wages and overtime for nurse aide training and testing. This adjustment does not apply to ICF/MR facilities. Beginning with dates of service July 1, 1992, and after, the Department will not adjust reimbursement rates for the cost of replacement wages and overtime for nurse aide training and testing because these costs are included in the 1991 cost reports.

J. Public Process

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

PART II - CHAPTER 1000

BASIS FOR REIMBURSEMENT

1001. General

This chapter provides an explanation of the Department's reimbursement methodology, including reimbursement rates, recipient eligibility, prior approval, service limitations, and coordination of other third party coverage.

1002. Reimbursement Methodology

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Effective with dates of service July 1, 1999 and thereafter, a facility's Actual Reimbursement Rate is the amount the Department will reimburse to a facility for nursing services rendered to a particular eligible patient for one patient day and is calculated by subtracting Patient Income from Total Allowed Per Diem Billing Rate. The Actual Reimbursement Rate is always subject to prospective adjustment to effectuate the policies described in this chapter. In addition, it is subject to retroactive adjustment according to the relevant provisions of Chapter 400 and Section 504 of Part I of this manual.

1002.1 Definitions

a. Patient Income is that dollar amount shown on Form DMA-59, Authorization for Nursing Facility Reimbursement, Section II - Admission, Subsection - "Patient Income," or, if the patient's financial status has changed, Section III. The patient's income is deducted in full from the Medicaid reimbursement rate until the income has been exhausted.

b. Total Allowed Per Diem Billing Rate is the amount derived from the rate setting process, as defined in Sections 1002.2 and 1002.3.

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c. A nursing facility is an institution licensed and regulated to provide skilled care, intermediate care, or intermediate care services for the mentally retarded in accordance with the provisions of this Manual. For reimbursement purposes, effective October 1, 1990, nursing facilities including hospital based facilities are divided into four types based upon the mix of Medicaid patients residing in the facilities on September 30, 1990 and after. The type classification of a nursing facility may change as described in the footnotes. The four types are described below: